Comparison of Health Plan Benefits Offered for 2007[1]

Plan	SHP Savings Plan		SHP Standard Plan[3]		BlueChoice HealthPlan of South Carolina[3]	CIGNA HMO[3]	MUSC Options[3]		Medicare Supplemental Plan[3]
Availability	Coverage worldwide		Coverage worldwide		Available in all South Carolina counties Coverage worldwide	Available in all South Carolina counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, McCormick and Saluda counties*	Available in these South Carolina counties: *Berkeley, Charleston, Colleton and Dorchester counties*		Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
Active Employee Monthly Premiums *Employee Only* *Employee/Spouse* *Employee/Children* *Full Family*	**$ 9.28** **$ 72.56** **$ 20.28** **$108.56**		**$ 93.46** **$237.50** **$142.46** **$294.58**		**$126.62** **$369.88** **$272.18** **$547.26**	**$124.10** **$359.60** **$263.74** **$531.32**	**$178.08** **$468.36** **$316.72** **$594.26**		Refer to the premium tables on pages 10-11 for rates
	Please note that premiums for optional employer groups, such as local subdivisions, may vary. <u>To verify your rates, contact your benefits office.</u>								
Annual Deductible *Single* *Family*	**(no per-occurrence deductibles)** **$3,000** **$6,000**		**$350** **$700**		**$250** **$500**	NONE	**In-network** NONE	**Out-of-network** **$500** **$1,500**	Pays Medicare Part A and Part B deductibles
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	HMO pays 90% after copays You pay 10%	HMO pays 80% after copays You pay 20%	HMO pays 100% after copays	HMO pays 60% of allowance You pay 40%	Pays Part B coinsurance of 20%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$1,500** **$3,000** **(excludes deductible)**	**$2,000** **$4,000** **(includes inpatient, outpatient, copays and coinsurance)**	N/A	**$3,000** **$9,000** **(excludes deductible)**	None
Physicians Office Visits	Chiropractic payments limited to **$500** a year, per person No per-occurrence deductible or copayments		**$10** per-occurrence deductible, then:		**$15** PCP copayment **$15** OB/GYN well woman exam **$30** specialist copay	**$20** PCP copayment **$40** OB/GYN exam **$40** specialist copay	**$25** PCP copay; **$25** OB/GYN well woman exam; **$55** specialist copay	HMO pays 60% of allowance after annual deductible You pay 40%. No preventive care benefits out-of-network	Pays Part B coinsurance of 20%
	In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%					
Hospitalization/ Emergency Care	No per-occurrence deductibles or copayments		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible		Inpatient: **$200** copay Outpatient: **$75** copay/first 3 visits Emergency care: **$100** copay HMO pays 90% after copays You pay 10% **$35** urgent care copay, then HMO pays 100%	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Inpatient: **$300** copay Outpatient facility: **$100**[2] copay Emergency Care: **$150** copay; **$50** urgent care copay	HMO pays 60% of allowance after annual deductible You pay 40% Emergency care: **$150** copay	**For inpatient hospital stays**, the Plan pays: Medicare deductible; coinsurance for days 61-90; coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required) **For skilled nursing facility care**, the Plan pays coinsurance for days 21-100; 100% beyond 100 days, up to $6,000 per year.
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowable cost until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable cost; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable charge.		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand Copayment max: **$2,500**		Participating pharmacies only (31-day supply): **$8** generic, **$30** preferred brand, **$50** non-preferred brand, **$75** specialty pharmaceuticals Mail order (Up to 90-day supply):**$16** generic, **$60** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	**$100** deductible, then: Participating pharmacies only (up to 30-day supply): **$10** generic, **$30** preferred brand, **$50** non-preferred brand, **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$25** generic, **$75** preferred brand, **$125** non-preferred brand		Participating pharmacies only (up to 31-day supply): **$10** generic, **$25** preferred brand, **$40** non-preferred brand Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand; Co-payment max: **$2,500**

[1]Premiums for subscribers of experience-rated groups (such as cities, counties and other local subdivisions) may increase, decrease or remain the same, based on the group's rating. If you are a subscriber of an experience-rated group, your benefits office will announce next year's rates.

[2]There will be no copayment for services performed at MUSC outpatient facilities.

[3]Refer to your 2006 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.